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JAPANESE HEALTH-CARE SYSTEM NO PANACEA FOR AILING U.S. PROGRAM

Summary

The litany of what works with the Japanese health care system could make Americans sick with envy, if viewed only superficially. The Japanese have apparent good health, as judged by longevity and infant mortality rates. Plus, the increase in national expenditures for medical care in recent years has been within several percentage points of economic growth rates. That contrasts with the double-digit rise in national medical expenses in this country. Moreover, Japan's system of health insurance covers almost all its citizens, while a woeful 35 million or so Americans have neither private nor government insurance coverage.

Access, affordability and, by extension, cost containment are key components in plans being drafted to help make America's health statistics rosier for a greater number of people. Adequacy, too, is important since access is not likely to be attained at the loss of technology. A closer look at the Japanese system points to problems in some areas and incompatibilities in others for those who might be seeking a model. Questions about who pays for health care as well as insurance, how cost containment is approached, the role of income equity and underlying attitudes toward medical care offer insights into the Japanese system's strengths and weaknesses.

Seeking a Cure for System Deficiencies

When America's health system performs well, it performs very, very well -- at a cost. But for those 33 to 35 million Americans who have no health

insurance or the infants who have a better chance of early life survival in some developing countries than they do in U.S. inner cities, the system is patently insufficient. Heard more and more in America are two questions: What is this country getting when it spends more of its gross national product on medical care than any other leading industrialized nation -- 12.2 percent in 1990 compared with 11.6 percent the year before -- and who is not benefiting. In fiscal year 1989, which ended March 31, 1990, Japan spent 4.9 percent of its GNP on health care. Life expectancy that year in Japan was the world's highest at 81.8 years for women and 75.9 for men. Its infant mortality rate is one of the world's lowest. And access to health care is nearly universal.

These few indicators do not necessarily make Japan a logical model as U.S. policymakers set about to draft improvements in America's health system. Since every country has its particular concerns and approaches to health services as well as financing methods, system revision cannot merely copy another country's format. Interestingly, however, few domestic proposals for change have drawn on aspects of Japan's system. Those suggesting ways to cure U.S. health-care deficiencies typically have looked at other nations' programs, particularly Canada's and Germany's.[1]

Japan's insurance system has components similar to both and, in fact, planners originally looked to Germany when establishing the country's first employment-based insurance fund. Like Germany's "sickness" funds, Japan's job-related insurance societies provide health coverage to the majority of the population. (For an overview of Japan's health insurance system, see JEI Report No. 16A, April 21, 1989.) For the approximately 36 percent of the population not eligible for some type of work-linked insurance, national health insurance coverage is available through local government programs under central government supervision. This has some similarities to Canada's province-centered programs. Also similar is the element of patient choice of hospitals and personal physicians.

Relatively easy access to care is not, however, a sufficient criteria for Japan serving as a model. Also crucial is affordability, not just as it relates to insurance coverage but to the ability of the system to control overall costs. This also involves adaptability to technological progress and changes in demographics and disease patterns.

[1]Democratic staff members who developed S 1227, HealthAmerica: Affordable Health Care for All Americans Act, have noted that while they studied a broad range of systems, they found elements in Germany's employment-based insurance system and its use of multiple payers to be potentially the most compatible with the existing U.S. system. For a look at various countries' health insurance programs, see Karen Horkitz, International Benefits: Part One -- Health Care, EBRI Issue Brief No. 106 (Washington, D.C.: Employee Benefit Research Institute, September 1990). For comparisons of selected international health systems, see Appendix.

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A Health System That's Relatively Painless

Even if a sick or injured Japanese visitor receives excellent care in an American medical setting, he or she most likely will suffer some confusion over payment. Provided that the patient has insurance coverage of some type, there are several questions, and the responses often vary from doctor's office to doctor's office. Does the insured pay the entire bill and ask for reimbursement from the insurance company? Does he or she ask the doctor to send the entire bill to the insurer and wait to determine how much must be paid out of pocket? Does the patient make an immediate copayment and wait for an insurer to determine how much, if any, of the rest is covered by a deductible and how much remains to be paid? In Japan the payment process is much simpler, as is the insurance component in general.

Copayments, a set percentage, depend on the type of insurance coverage and whether the medical care was for inpatient or outpatient services. Under national health insurance (which includes coverage for farmers, self-employed people and those working in offices with less than five people) the copayment is 30 percent of the outpatient dependent's bill; for most primary (employed) beneficiaries the copayment is only 10 percent of the bill (see Table 1). Those on public assistance pay a percentage, if anything. Senior citizens, aged 70 and older, face charges of at most Y400 ($2.96 at Y135=$1.00) a day for inpatient treatment and Y800 ($5.93) a month for outpatient services. They pay no premiums since 70 percent of the elderly insurance fund comes from contributions made by workers' insurance funds and the national insurance fund; the central government supplies 20 percent and local governments subsidize 10 percent.

Once this copayment has been made, the patient has no more involvement with the bill. (Private insurance claims for semiprivate or private hospital rooms or other items not covered under regular insurance are the patient's responsibility, however.) The medical provider (doctor or hospital) submits the remainder of the claim to a government-run bill examination and payment office, which sends approved claims to the insuring organization (such as the 167 national health insurance associations, 3,429 local governments operating NHI programs, the 1,814 insurance societies, mutual aid associations or the central government's Social Insurance Agency). U.S. studies have estimated that a centralized billing system would reduce overhead costs by between 2 and 13 percent.[2] Not only do U.S. patients suffer from billing confusion but providers here are swamped by the paperwork necessary for myriad, disparate insurers.

Equally straightforward in Japan is the process for obtaining insurance. Although there are some exceptions, every person employed in a business with five or more people must be insured. (Among the exceptions are private employees in the agriculture, forestry and fisheries sector, people who do seasonal labor for less than four consecutive months, those who work at an unfixed location and workers employed on a daily basis or for less than two months. These people are eligible to join the national health insurance system.) If a person works for a company that has set up an insurance entity, enrollment is automatic with that association. Generally, such companies must have more than 300

[2]Congressional Budget Office, Rising Health Care Costs: Causes, Implications and Strategies (Washington, D.C.: April 1991), p. 50.

Table 1: Estimated Health Care Premiums, Payments and Benefits by Those Under Age 70* at December 1989 Rates

Type of Insurance	Number Enrolled: Insured	Number Enrolled: Dependents	Premiums	Sample Payments	Benefits: Insured	Benefits: Dependent	State Subsidy
Government-Managed	16,718,804	17,945,707	8.3% of SMR** plus 1% of bonus***; FY 1988 average: Y226,648.	Y19,211/month for typical male worker; Y13,114/month for typical female worker.	90%	80% (inpatient) 70% (outpatient)	16.4% of benefit costs
General (28% of coverage)	16,594,829	17,883,707					
Day Laborers (0.1% of coverage)	123,975	62,000	Fixed rate varies; split about 60-40; FY 1988 average included above.	Laborer paid a daily wage of Y14,000 would pay about Y545/day, the employer Y885/day.	90%	80% (inpatient) 70% (outpatient)	16.4% of benefit costs
Society-Managed (25.3% of coverage)	13,720,670	17,366,797	3% to 9.5% of SMR plus up to 1% of bonus; FY 1988 average of 8.3% or Y270,599 per worker; usual split 4.15%; employee pays 0.3% of bonus, employer 0.5%.	Y14,933/month for typical male worker paying 4.5% of SMR; typical female worker would pay Y8,353/month at 4.5% of SMR. Worker's share may be nothing, depending on employer. Total premium could hit Y31,525/month for typical male worker (9.5% of SMR).	90%	80% (inpatient) 70% (outpatient)	Y7.75 billion; fixed FY 1989
Mutual Aid Associations (9.8% of coverage)	5,062,000	7,029,000	Average of 8.1% of SMR.	Y24,201/month for federal employee in association (if pays full amount); Y24,832/month for federal employee in federation paying total; Y21,477/month for local government worker paying full amount.	90%	80% (inpatient) 70% (outpatient)	None
National Health Insurance (36.3% of coverage)			FY 1988 per person average: Y57,855.				
Local Governments	40,690,110	n.a.	Determined by local rules but not to top Y420,000/year per household.		70% in general but 80% for retiree and 80% for retiree's dependent as inpatient and 70% as outpatient (retiree must be former member of employee insurance group)		50% of benefit costs
NHI Associations	3,924,089	n.a.	Average: Y57,855/year; fixed by local rules but not to top Y420,000/year per household.				30-50% of benefit costs (none for retiree on NHI)

*Those aged 70 and over plus those aged 65 and bedridden are eligible for Health Insurance for the Elderly, which covers 100 percent of costs with an inpatient copayment of Y400 a day and an outpatient payment of Y800 a month.

**Standard monthly remuneration. A typical male worker under the government-managed scheme had a monthly standard remuneration in FY 1989 of Y269,653. The typical female worker in such a case earned Y156,120. A typical male worker under the society-managed plan had a standard monthly remuneration of Y331,837 in FY 1989. The typical female worker's SMR was Y185,616. The standard monthly remuneration does not include bonuses, which might be the equivalent of two to three months SMR.

***In principle this is to be shared equally by employer and insured. For government-managed health insurance the government subsidizes two-fifths of the amount of the insured person's contribution. Insurance societies can determine whether to impose the contribution within the 1% limit.

Source: Ministry of Health and Welfare, Insurance Bureau

employees on the payroll. The government can require firms with more than 500 workers (including those in subsidiaries) to set up a health insurance society.

Through mandatory or voluntary participation an estimated 99 percent of the Japanese population is insured by either an employee-based insurance group, the national health insurance program or the Health Services Scheme for the Aged. As Table 1 shows, premiums vary widely. The most prestigious firms -- generally the largest -- might agree to cover the entire premium for workers enrolled in society-managed funds. Those employed by small or medium-sized firms may end up paying the entire premium on their own. And, just as in the United States, the self-employed who want insurance pay the entire amount themselves. A difference is that a critically ill Japanese worker is assured of being able to obtain insurance and does not have to worry about ineligibility because of preexisting conditions -- a problem found in the risk-averse coverage available from insurance companies in the United States. Selectivity for the insured exists indirectly in Japan, since employee insurance groups generally consist of those aged 55 or younger.

Disparities in what various participants contribute and the copayments that they make were the target of 1984 health-care reforms. Previously, copayment rates varied from nothing to 30 percent, depending on the insurance program. Now, workers not under the national health insurance plan face a uniform copayment of 10 percent (those enrolled in the NHI plan still pay 30 percent). Additionally, by creating a separate fund for the elderly the government tried to cut the high proportion of seniors enrolled in the national insurance plan. (The implications of this move will be addressed below.)

Another inequity posed by Japan's national health insurance scheme is that participants in some parts of the country may pay premiums 7.5 times greater than participants in the same scheme in a different municipality. (Locational differences in America also pose problems: 8.3 percent of the nonelderly population in Michigan is without health insurance, while 28.1 percent go without in New Mexico.[3]) The Ministry of Health and Welfare blames the high-end charges on a larger elderly population in the community, a greater number of hospital beds and more health awareness. In 1989 the ministry designated 147 localities as having extraordinarily high medical expenditures and urged them to rationalize their costs.

Effects of Rising Costs on Participants

Just as Washington has struggled to contain the rise in payments by the Medicare program for those aged 65 or older and the eligible disabled, Tokyo, too, is looking at ways to contain costs and utilization. Affordability of health care has different implications in the United States and Japan. Americans without insurance or with minimal coverage might be denied medical care, or avoid seeking it. One result is a system that treats the better-off and the very poor but ignores those that cannot afford care. The projected long-run impact of delayed care is a sicker patient eventually and higher medical bills that care providers will seek to recover either from government subsidies (giving state and federal governments cause for involvement) or by cost-shifting to insured patients. American employers, too, suffer as they try to configure

[3]Horkitz, op. cit., p. 6.

their benefits packages to avoid bearing the brunt of the escalating costs of medical care yet still attract quality employees and keep them healthy.

As regards affordability, Japan and other countries with variations of universal medical insurance coverage already accept one principle not yet confirmed by U.S. policymakers: that basic levels of health care are a citizen's right. Thus, while Washington neither guarantees access to health care for the public at large nor affordable health care for all citizens, Tokyo is required by the constitution (Article 25, Clause 2) to exercise responsibility for public health and social welfare.

Affordability for both payer and purchaser is a crucial element in a system of guaranteed access to health care. Whether to control costs by cost-sharing among participants, limitations on benefits or regulated fees and prices -- the usual trio of methods -- becomes a matter of public policy when the government is involved as a payer. Japan focused mostly on cost-sharing and regulation in the 1980s. Controlling costs is particularly important because Tokyo underwrites 50 percent of the national health insurance scheme and provides a more limited 16.4 percent subsidy for the government-managed insurance fund.

Government Role - In general the government pays about 31 percent of Japan's health care costs (see Table 2).[4] A steady climb in medical costs (see Table 3) is one reason the Ministry of Health and Welfare began introducing a

Table 2: Japan's Health-Care Receipts by Source of Funds, FY 1988-FY 1989

(in trillions of yen and billions of dollars*)

	FY 1988			FY 1989		
	Amount		Percent	Amount		Percent
	Yen	Dollars	of Total	Yen	Dollars	of Total
Government	Y5.85	$45.6	31.2%	Y6.20	$43.4	31.4%
Insurance System**	10.53	82.1	56.2	11.06	77.5	56.1
Patient Out of Pocket	2.32	18.1	12.4	2.42	17.0	12.3
Other	0.05	0.4	0.2	0.05	0.3	0.2
Total Receipts	18.76	146.2	100.0	19.73	138.1	100.0

*The FY 1988 figures were converted using Y128.26=$1.00; the FY 1989 exchange rate was Y142.83=$1.00.
**Includes company and employee contributions.

Source: Ministry of Health and Welfare

[4]A study by Katharine Levit and Cathy Cowan, "The burden of health care costs: Business, households and governments," Health Care Financing Review, XII, No. 2 (Winter 1990), pp. 127-137, indicates that the U.S. government also pays about 31 percent if judged solely by what the federal government contributes as subsidies and not what it pays as an employer. A traditional model shows the public sector contributing 42 percent if the above factors are not discounted (see Appendix).

Table 3: Indicators of Japan's Medical Expenditures, FY 1985-FY 1989

(in billions of yen)

	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989
National Medical-Care Costs	Y16,015.9	Y17,069.0	Y18,075.9	Y18,755.4	Y19,729.0
Change	6.1%	6.6%	5.9%	3.8%	5.2%
National Medical-Care Costs as Share of GNP	4.9%	5.0%	5.1%	4.9%	4.9%
Change in GNP	6.4%	4.4%	4.9%	6.4%	7.2%
Medical-Care Outlays for Seniors	Y4,067.3	Y4,437.7	Y4,830.9	Y5,000.2	Y5,409.7
Change	12.7%	9.1%	8.9%	3.5%	8.2%
Cost of Senior Care as Share of National Medical Care	25.4%	26.0%	26.7%	26.7%	27.4%

Source: Management and Coordination Agency, Statistics Bureau, Japan Statistical Yearbook 1990, and Ministry of Health and Welfare.

variety of reforms in the 1980s. Another catalyst was the cabinet's 10 percent across-the-board cut in proposed discretionary spending for FY 1984 as Tokyo tried to tackle its budget deficit.[5] Among MHW's reforms were those requiring primary beneficiaries to be responsible for a 10 percent copayment (before coverage was 100 percent for some workers) and revising schedules for medical fees and drug prices.

Nevertheless, financial problems continue to plague government-affiliated health-care programs. Of the 3,429 local government units providing national health insurance coverage, 261 had a combined deficit of Y114.7 billion ($849.6 million) in FY 1988. The year before the general government-managed health insurance fund recorded a deficit, as did the mutual aid association funds that cover employees working for government-affiliated organizations (see Table 4). It is not readily apparent whether the rising costs have hit government or patients the hardest. The government's 31 percent contribution to health-care funding compares with a 12 percent patient out-of-pocket contribution (Table 2). The 12 percent figure, however, does not include any premium payments, which would be included under the insurance system category. Yet a worker might pay the entire premium or as much as half, depending on what share his or her employer pays to the insurance fund.

Patient's Involvement - Patients feel the weight of increases in medical costs either by adjustments in their premiums or the copayments they must make. As noted earlier, the cost of premiums varies greatly, depending on employment,

[5]Mitsuru Fujii and Michael Reich, "Rising medical costs and the reform of Japan's health insurance system," Health Policy, IX, 1988, pp. 9-24.

Table 4: Financial Results of Various Japanese Insurance Programs, FY 1985-FY 1987

(in billions of yen)

Program	Fiscal Year	Net Revenues	Expenditures	Balance
Government-Managed	1985	Y3,889	Y3,623	Y266
	1986	3,981	3,940	41
	1987	4,181	4,318	-137
Society-Managed	1985	3,401	3,056	345
	1986	3,543	3,295	248
	1987	3,685	3,660	25
Mutual Aid Associations (for central government ministries and agencies)	1985	1,576	1,202	374
	1986	1,697	1,329	368
	1987	1,833	1,539	294
Mutual Aid Associations (for central government-affiliated organizations)	1985	1,266	1,143	123
	1986	1,233	1,224	9
	1987	1,352	1,387	-35
Mutual Aid Associations (for local governments)	1985	4,455	2,990	1,465
	1986	4,947	3,438	1,509
	1987	5,171	3,871	1,300
National Insurance	1985	5,001	5,165	-164
	1986	5,460	5,355	105
	1987	5,735	5,749	-14

Source: Management and Coordination Agency, Statistics Bureau, Japan Statistical Yearbook 1990.

age and sometimes location. People employed by major corporations typically pay only part of their premiums and possibly have access to in-house medical facilities as well (see JEI Report No. 40A, October 19, 1990). Health associations might provide more extensive cost-sharing for normal pregnancies, which are not covered under basic benefits. The value of delivery and childbirth coverage to participants in the government-managed employee-based system is clear from Table 5. Members of employee-based insurance funds also benefit in that when they retire and, typically, join the national health insurance program, they are eligible for 80 percent coverage instead of the 70 percent accorded most NHI enrollees. As health policy analysts Mitsuru Fujii and Michael Reich point out, however, this contributes to cross-generational inequities in the insurance program.[6]

Since health associations' membership is limited to only those who are employed (and fairly healthy by virtue of relative youth), not only are these funds' expected expenditures lower than that of the national health insurance

[6]Ibid., p. 16.

Table 5: Coverage by Type of Insurance Plan in Japan, 1988

	Government-Managed		Society-Managed	National Health Insurance*
	General	Day Laborers		
Insured (thousands)	16,595	124	13,721	45,338
Medical Care				
Cases** (thousands)	118,881	1,386	85,649	271,218
Value (billions)	Y1,737	Y22	Y1,125	Y4,860
Sickness and Injury				
Cases (thousands)	1,249			
Value (billions)	Y139			
Delivery and Childbirth				
Cases*** (thousands)	234			310
Value (billions)	Y49			Y38
Other****				
Cases (thousands)	35		19,722	1,291
Value (billions)	Y9		Y113	Y27
Dependents (thousands)	17,884	n.a.	17,367	n.a.
Medical Care				
Cases (thousands)	115,029	308	116,111	
Value (billions)	Y1,092	Y5	Y953	
Spouse Delivery				
Cases (thousands)	311			
Value (billions)	Y62			
Spouse Child Care				
Cases (thousands)	306			
Value (billions)	Y0.6			

*Data for 1987.
**Includes benefits for retired employees under the Medical Care System for Retired Persons for national health insurance only.
***Delivery and childbirth expenses under national insurance are for midwifery benefits.
****Includes funeral expenses and unspecified benefits.

Source: Management and Coordination Agency, Statistics Bureau, Japan Statistical Yearbook 1990.

plan but copayments typically are lower, too. For example, in FY 1988 the average medical-care expenditure for an enrollee in a society-managed health fund was Y78,331 ($580); the copayment would have been Y7,833 ($58). The average cost for a dependent in a society-managed fund was Y65,733 ($487), of which Y13,147 ($97) would have been required as a copayment if all the costs were for inpatient services. The national insurance fund, which includes retirees of an age where health problems crop up frequently, averaged payments per enrollee of Y182,157 or $1,349, the highest of any of the funds; the copayment for a nonretiree would have been Y54,647 ($405) and Y36,431 ($270) for a retiree.

The inequities in the system are addressed only partially by a fund-redistribution plan the government imposed when it enacted the Health Services

Law for the Aged in 1983. This law commits a portion of the premiums paid to employee-based insurance funds to pay for retiree insurance. The insulation provided to the employee-linked associations from the expected demands of an expanding elderly population may not last, however. Among the ideas that have been proposed but not enacted are a hike in the copayment to 20 percent and exclusion of people with high incomes from insurance coverage.[7]

Various studies in the United States and elsewhere have indicated that higher copayments cut back the demand for medical care to a certain point.[8] Messrs. Fujii and Reich also noted that Japan's introduction of a 10 percent cost-sharing requirement for those covered by employee insurance "seems to have reduced the number of consultations sought. . . ."[9] Nevertheless, costs have continued to rise in Japan. Antidotes to the problem will be addressed later.

Employer's Posture - In the United States the role of benefits in wage and salary negotiations has mirrored the rise in medical costs. But Japanese employers in the latest spring wage talks heard more demands for vacations or shorter work weeks (see JEI Report No. 12B, March 29, 1991). Although companies that have employee-based health funds can adjust premiums to some degree, the variations have an upper limit set by the government and a practical limit set by competition with other employers in a tight labor market.

The average monthly cost of health insurance for firms surveyed for a Ministry of Labor study printed in 1988 found that one-third of the mandated benefits paid by employers was for health insurance or about 3 percent of the total monthly standard remuneration (which excludes bonuses). The average of surveyed firms across all industries was Y10,831 a month ($80), with the highest figure -- Y18,641 ($138) -- for utility company employees. These amounts do not include voluntary provision of health-care benefits, which amounted to a monthly average per employee of Y1,144 ($8.47). Although the measures are different, it is interesting to note that U.S. companies covered about 30 percent or $173.4 billion of total domestic expenditures in 1989 for health services and supplies, according to data from the Health Care Financing Administration. This figure, up 12.3 percent from 1988, included $128.8 billion for employees' private health insurance policies and another $28.5 billion as the employer's contribution under mandated rules for Medicare contributions.[10]

Perhaps hinting at the low level of involvement by the average employer in Japan's health-care system, an ad hoc committee for administrative reform proposed in 1981 that the government work to increase the participation of the private sector in coping with the strains on the social security system, the broad designation for Japan's social security and health insurance systems.[11] Keidanren (Japan Federation of Economic Organizations) has responded with papers addressing the need to cope with the increasing numbers of elderly in Japan, estimated to exceed one-fifth of the population by the year 2020.

[7] Ibid., p. 16.

[8] Congressional Budget Office, op. cit., p. 34.

[9] Fujii and Reich, op. cit., p. 19.

[10] Levit and Cowan, op. cit., p. 129.

[11] Fujii and Reich, op. cit., p. 15.

The impact on health-care expenditures of the growing elderly population could be significant, reaching 42.4 percent in the year 2000 (see Table 6). A 1990 report on Japan's economy by the Paris-based Organization for Economic Cooperation and Development furthermore warned that by the year 2020, the elderly could account for over half the nation's medical expenditures if the estimated 4.8-to-1 ratio of per capita spending for elderly to nonelderly remains constant. This compares with a 3.9:1 ratio in the United States in elderly to nonelderly health spending per capita. Yet the OECD figured that the United States would spend a slightly greater percentage on its elderly in 2020 than Japan would.[12]

Table 6: Average Annual Nominal and Real Growth in Various Countries' Health Expenditures, 1960-84

		Real Expenditures Due to Changes in:		Outlays and Projected* Outlays for Senior Care as Share of Total		
	Nominal Expenditures	Demographics	Per Capita Increases	1980	2000	2020
Japan	16.8%	1.1%	9.1%	31.3%	42.4%	52.5%
United States	11.8	1.1	4.1	47.0	48.8	56.9
Germany	10.1	0.4	3.8	32.7	34.1	40.0
France	15.3	0.8	7.0	28.4	30.0	35.8
United Kingdom	13.1	0.3	4.1	42.5	43.0	45.6
Italy	17.6	0.5	5.9	33.2	34.3	38.9
Canada	12.5	1.4	5.1	32.4	39.4	48.9

*Assumes constant per capita expenditure by age.

Source: Organization for Economic Cooperation and Development, Financing and Delivering Health Care (Paris: 1987).

Cost-Saving Efforts

Government's involvement as one of many payers for health care poses a risk that policy will favor economics at the expense of good medical practice. Messrs. Fujii and Reich have written that "health insurance policy seems to be leading medical services policy" in Japan.[13] The heavy component of private, fee-for-service care providers complicates the government's attempt to control costs. Further intruding on efforts to restrict rising costs is Japan's ever-higher standard of living, which began improving at the same time as medical procedures became increasingly complex and costly. The OECD calculated that Japan outpaced all other leading industrialized countries in its inflation-adjusted public health expenditures for the years 1960 through 1984 (Table 6). Karen Horkitz, writing on international health-care expenditures for the Employee Benefit Research Institute, noted that at least one report has pointed to a positive correlation between the rise in individual incomes and per capita

[12]Organization for Economic Cooperation and Development, OECD Economic Surveys: Japan (Paris: 1990), p. 79.

[13]Fujii and Reich, op. cit., p. 20.

consumption of health care services.[14] Not surprisingly, as Japan's per capita income climbed in the 1970s and 1980s medical services began using increasingly complex, and costly, equipment (see Table 7).

Table 7: Installation of Various Types of Complex Equipment in Japanese Hospitals, 1981 and 1987

Type of Equipment	1981 Number of Hospitals	1981 Pieces of Equipment	1987 Number of Hospitals	1987 Pieces of Equipment
Whole Body Computerized Tomography Scanners	647	664	3,018	3,224
Head-Only CT Scanners	904	910	937	944
Fibertracheobronchoscope	1,813	3,518	2,932	5,935
Fibergastroscope	5,429	13,668	6,508	15,824
Hemodialysis Apparatus	1,285	13,405	1,687	21,456
Electroencephalographs	--	--	5,992	7,468
Echographs	4,706	7,519	7,230	14,420

Source: Ministry of Health and Welfare, Statistics and Information Department, "Report on Survey of Medical Care Institutions."

Nevertheless, the government is mixing its efforts to adjust financing of health services with regulations on the supply side of medical care. Not all its plans have met success. The number of hospitals as well as the number of hospital beds have continued to expand despite attempted limits on the expansion of medical facilities (see Table 8). Observers of the health-care system suggest that efforts to regulate medical fees and pharmaceutical prices simply result in suppliers calling for more procedures or issuing more prescriptions to maintain their income levels. The same complaint echoes in the United States, where various spin-off effects have pushed up utilization to counter the government's moves to stem the rise in costs affecting Medicare programs.

Facility Regulation - The government's attempt to control the expansion of medical equipment and facilities, a counterpart to America's 1974 certificate-of-need legislation, is based on the 1948 Medical Services Law, which gave prefectural governments the duty of developing regional needs plans. Prefectures also are responsible for evaluating the construction and the staffing of new facilities. Yet the oversupply issue has not been clearly stressed. "The Japanese assumption appears to be that any excessive hospital construction will be controlled by competition," according to health policy analyst Milton Roemer.[15] A 1985 amendment to the Medical Services Law did focus on controlling expansion of the number of hospital beds. (Studies in both Canada and the United States have indicated that as the number of hospital beds climbs so does usage.) Analysts Fujii and Reich noted, however, that the amendment's success

[14]Horkitz, op. cit., pp. 25-26.

[15]Milton Roemer, National Health Systems of the World, Vol. 1, The Countries (New York, N.Y.: Oxford University Press, 1991).

Table 8: Hospitals and Number of Beds by Ownership in Japan, 1980 and 1988

	1980		1988	
Type of Founder	Hospitals	Number of Beds	Hospitals	Number of Beds
Government	452	--	402	159,474
Other Public Groups*	1,369	--	1,368	342,403
Social Insurance Bodies	140	--	137	38,109
Medical Juridical Persons	2,896	--	3,855	599,819
Individuals	3,433	--	3,410	287,469
Other**	764	--	862	207,035
Total	9,055	1,319,406	10,034	1,634,309

*Includes hospitals established by local governments as well as the Red Cross and certain other public bodies.
**Includes company-owned hospitals, school-affiliated hospitals and public welfare juridical persons.

Source: Ministry of Health and Welfare, Health and Welfare Statistics in Japan 1990, and Management and Coordination Agency, Statistics Bureau, Japan Statistical Yearbook 1990.

has been questioned on two fronts. "While the amendment does control the addition of new beds, it does not provide authority to reduce the number of existing beds, when they may already be in excess. Moreover, rather than reducing the total number of beds, the regulation provides a rationale for adding new beds in areas where numbers are currently below the approved level."[16]

The Ministry of Health and Welfare in a report on an October 1989 survey credited local regulators for keeping the annual growth of hospitals to 0.5 percent. The addition of 47 hospitals brought the late 1989 total to 10,081; a 1.7 percent increase in hospital beds brought the number to about 1,669,520.[17]

Also factoring into attempted regulation of facility and equipment expansion is the power of the Japan Medical Association. Of the approximately 194,000 physicians in Japan, 121,514 belonged to JMA as of December 1990. Critics have said that JMA's influence also has thwarted implementation of any outside peer review, one of the methods attempted in the United States to challenge unnecessary medical procedures.

Regulation of Fees - Japan's fee-for-service medical system has operated under a government-set fee system since 1958. Revisions every two years attempt to keep the fees up-to-date, although JMA continually pushes for greater increases. In its most recent decision to review the 7,000 or so regulated fees MHW said that the system needs to be simplified. Among changes that a review

[16]Fujii and Reich, op. cit., p. 19.

[17]"Increase in Number of Hospitals Slows Down," The Japan Medical Review, V, No. 12, December 1990, pp. 3-4.

panel will be considering are: adjustments in prices to reflect urban/rural differences, the availability of medical facilities and their level of proficiency and a more U.S.-style reimbursement that evaluates an entire procedure (a diagnostic-related group) rather than the piecemeal approach now used in Japan.[18]

In a repeat of what most likely is heard in any country that attempts to regulate medical services, a major criticism of Japan's fee system is that doctors will find other ways to maintain or boost their income. International health analyst Roemer wrote, "The belief is widespread in Japan that physicians are abusing the health insurance program to enhance their earnings. The rate of appendectomies, for example, is extremely high -- three times the rate performed in England; more than 60 percent of appendices removed were found not to be inflamed."[19] Without significant peer review by an objective, preferably outside, organization such practices are likely to continue. Although the government attempts to check for billing fraud, its role is restricted in challenging physicians' professional opinions.

An associated complaint is that Japanese physicians supplement their income by selling the medication that they themselves prescribe. The practice has a dual return, Mr. Roemer noted. "Accordingly, it is often claimed that physicians customarily dispense only a small supply of drugs, so that the patient must return soon to be reexamined to receive an additional supply, as well as to yield a further fee."[20] Other critics have contended that a doctor's double role as prescriber and dispenser of drugs contributes to overprescription, a topic of considerable debate.[21] Mr. Reich pointed out that since pharmaceuticals carry more points for reimbursement than medical services, physicians have an added incentive to prescribe more drugs.[22] The Health and Welfare Ministry, however, has threatened to revise this practice by separating the prescribing and the dispensing powers.

Pharmaceutical Pricing - The tie-in between physicians prescribing and selling drugs has frustrated pharmaceutical companies, which are squeezed by the government's pricing controls and a desire to encourage physicians to prescribe their products over those of a competitor. When the government began drastically cutting the amount that it would reimburse for medications in the 1980s, drug firms generally cut their profit margins to continue offering discounts to physicians through wholesalers. Another result of the restricted reimbursement policy, however, was to increase drug companies' attention to new

[18]"Drastic Review of Current Medical Fee System Under Way," The Japan Medical Review, VI, No. 2, February 1991, p. 3.

[19]Roemer, op. cit., p. 160.

[20]Ibid.

[21]Michael Reich, "Why the Japanese Don't Export More Pharmaceuticals: Health Policy as Industrial Policy," California Management Review, XXXII, Winter 1990, p. 147.

[22]Ibid.

drugs, which could be priced higher since they had no precedents. Health analyst Reich noted that physicians, too, ended up prescribing the drugs that had higher profit margins and, thus, better discounts.[23] One effect of the cuts in drug reimbursement rates has been to shift the attention of Japanese pharmaceutical houses to overseas markets, Mr. Reich added.

An area in which pharmaceutical companies benefit under current U.S. law is the manufacture of orphan drugs. Under the orphan drug law a manufacturer is encouraged to develop a drug even if demand is slight because it is used to treat rare diseases. In turn, the government allows a monopoly on sales for a certain time. Japanese pharmaceutical firms have asked MHW to provide favorable taxation, simplified evaluation and approval procedures and exclusive sales rights for orphan drugs under a process similar to U.S. law.

As scientific advances lead to more sophisticated medications and medical procedures, cost controls will become more difficult to implement. For this reason alone cultural attitudes toward health and welfare carry important implications for a country's ability to control costs.

Basics Shape Costs

Good health is key to keeping medical costs low, which is one reason preventive medicine is touted. Typically associated with good health is an adequate income level. A low rate of alcohol or drug abuse or similar societal problems that impact a nation's health bill also is a factor. Still another important component is age, since the elderly use more medical services than the young.

Projections that its rapidly aging population would make up at least one-fifth of the entire population in just 30 years spurred Japan in the 1980s to institute programs offering health checkups to people 40 and older in a bid to encourage health maintenance. In late 1989 the government unveiled its 10-year strategy to promote health care and welfare for the elderly, focusing on research into aging and ways to improve the nation's ability to care for the elderly at home. The 39-day average general hospital stay in Japan -- a figure far surpassing that of any other industrialized nation -- stems primarily from the use of hospitals to care for bedridden elderly. The shortage of both long- and short-term skilled nursing facilities is another problem that officials hope to offset partially by implementing a home-care network. A recently organized study group on home care is considering, among other subjects, whether a family should be reimbursed for the cost of nursing.[24]

Income supplements are designed to address a variety of social problems in Japan, but the general trend has been for fewer people to receive public assistance payments. The 1988 rolls showed nearly 1.2 million recipients, down from a high of over 2 million in 1951. Overall expenditures hit a peak in 1985 of Y1.5 trillion ($11.1 billion) but by 1987 had fallen to Y1.4 trillion ($10.6 billion). Assistance for medical expenditures comprised the biggest component,

[23] Ibid.

[24] "Group Organized To Study Costs Of Home Care," The Japan Medical Review, VI, No. 1, January 1991, p. 3.

totaling Y68.2 billion ($505.5 million) in 1987, although this figure was off from the Y70.5 billion ($522.5 million) spent in 1985. Payments vary according to region, but for a three-member household that included a disabled father the payment in 1987 was Y136,444 ($1,011). Other forms of assistance include employment assistance and consideration for public housing. Among those eligible are fatherless families, motherless families and widows.

The Health and Welfare Ministry points to public assistance programs as one of the successful ways in which income is redistributed in Japan. Even more important have been improvements in the social security and the pension systems (see JEI Report No. 21A, May 25, 1990). The measure used to judge improvements in income redistribution, the Gini coefficient, shows that the combination of social security benefits, medical-care costs and initial income, minus social insurance premiums, was responsible for a 12 percent improvement in income equality in 1987, the highest ever in MHW's records. Since the high proportion of nonworkers enrolled in the national health insurance program (29.6 percent) is a worry, the income redistributive effects of social policy are important to MHW's efforts to stabilize the health insurance system's base. (For a broader look at economic equality issues, see JEI Report No. 4A, February 1, 1991.)

Societal problems have yet to play a seriously disruptive role in driving up the costs of Japanese health care, although concerns about alcoholism and overwork may be prompting more use of counseling centers. In 1987 people in alcohol dependence rehabilitation used only 5.2 percent of the mental hospitals' inpatient services and 2.7 percent of their outpatient services. The percentage used by those complaining of overwork, a relatively new complaint, was not listed. Offenses involving narcotics climbed to a high of 1,909 arrests in 1988, while those associated with illegal use of stimulants involved 20,716 people, down from a high of 24,372 in 1984. Should job-related stress or narcotics begin taking more of a toll in Japan, the health system would suffer.

Other factors that could affect the country's health-care system include improvements in its somewhat undeveloped emergency services system, which sometimes results in lives being saved on the margin; that brings about more long-term rehabilitation costs. The Japanese still are coming to grips with recognizing cessation of brain waves as the cause of death; therefore, doctors do only a limited number of transplants, primarily those involving kidneys, corneas or partial liver transplants. An interim report issued in mid-June by an advisory panel to Prime Minister Toshiki Kaifu said that brain death is sufficient for a medical declaration of death instead of the current Japanese definition of no heartbeat. The distinction is that organ transplants, particularly of the heart, are impractical once the heart has stopped beating. A brain-dead patient's heart, however, can be kept beating for a time to allow a transplant. One professor of thoracic surgery at Tohoku University summed up the feelings of many in Japan: "The panel's opinion is not equivalent to a social consensus on the matter." The professor added, "Carrying out an organ transplant without a social consensus will undoubtedly cause confusion."[25]

Intransferability Issues

Differences in social attitudes about medical care may be less of a factor than others in determining whether the Japanese system could be used as a

[25]"Brain Death Report Divides Experts," The Japan Times, June 15, 1991, p. 2.

model for Americans interested in changing their health-care system. The trust that the Japanese have tended to place in their doctors -- "the doctor is god" attitude -- certainly bodes ill for a country interested in controlling that doctor's income. Americans are more skeptical of a doctor's abilities, as the level of malpractice suits indicates. Yet Americans have not pursued to any great degree cost-based comparison shopping for medical services. This approach, naturally, is not possible in one-doctor towns across rural America. But few urban dwellers check fees and select their health-care provider accordingly. Corporations, which pay a growing portion of the American health-care bill, have headed for this route in trying to enroll employees in managed-care networks, such as health maintenance organizations. The competition model only works so far, however, since technological advances in equipment, pharmaceuticals and medical procedures will boost the prices of health care.

The Japanese health insurance system assures broad access as well as lower costs through single-payer overhead and government-negotiated fees for services and supplies. Moreover, patient confusion is minimized because the insurance system is highly regulated. Yet the costs to both consumers and the government are high. Although the trend is downward, Americans already pay far more out of pocket for health care than the average Japanese. Per capita expenditures in 1988 were $1,298 in this country and Y133,600 ($1,043 at 1988's average exchange rate of Y128.15=$1.00) in Japan -- with the Japanese paying from a lower base, perhaps due to regulated fees for all medical services and pharmaceuticals. The true cost for the individual Japanese, including copayments, is difficult to determine from available data, however, since Japanese employers have some discretion in premium payments.

Another roadblock to the transferability of the Japanese system to the United States is the importance of the network of multiple insurance vendors to the American health-care system. The insurance industry would not take kindly to a wholesale adoption of the Japanese system. Other countries, including Japan, have assigned an adjunct role to the insurance industry to supplement basic services.

The positive aspects of the Japanese system -- nearly universal access, choice of physician and hospital, shared premium costs, cross-group subsidies that help relieve any one group's burden, and fee systems that can respond to innovations in health care -- have to be weighed against some of the negatives. These include the burden on the government to subsidize cost overruns and to regulate fees in such a way that providers can continue to propose what is best for a patient without first consulting a calculator. Perhaps in reviewing the Japanese system's pluses and minuses, U.S. health-care policymakers will gain more insight into costs and opportunities as well as the benefits of building a system on solid bases.

For further information, contact Pat Murdo.

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The views expressed in this report are those of the author and do not necessarily represent those of the Japan Economic Institute.

APPENDIX

Table 1: International Comparison of Publicly Funded Medical-Care Systems, April 1989

	Japan	United States	United Kingdom	West Germany	France	Sweden
Type of System	Social Insurance	Social Insurance*	Health Service (medical care) Social Insurance (cash benefits)	Social Insurance	Social Insurance	Health Service (hospitalization) Social Insurance (outpatient, cash)
Application	All citizens via employee health insurance funds and national health insurance operations	Pension recipients aged 65 and over and people on disability pensions	Medical-care benefits for citizens; cash benefits	Broadly divided into general and farmer plans but differs by occupation; not compulsory for high-income people; covers 93% of population	Broadly divided into general, special, agricultural and self-employed but differs by occupation	Medical care benefits for all residents plus cash benefits for workers with annual earnings below set amount and most housewives
Scheme	Government-managed health insurance and national health insurance	Medicare, including hospitalization insurance (Part A) and supplementary medical insurance (Part B)	National Health Service (medical care) National Health Insurance (cash benefits)	General Sickness Insurance System	General System	National Health Service (hospitalization) National Insurance (outpatient)
Financial Resources Insured	Government-managed plans: 4.15% of standard monthly pay plus 0.3% of bonus; NHI: average 1988 amount per household of ¥138,600	Part A: 1.45% of pay up to annual ceiling of $48,000; Part B: $31.90/ month	Medical care: insured and employer share 15% of cost; cash benefits: 5%, 7% or 9% of weekly pay up to ceiling	6.7% of pay on average	5.9% of pay	None except self-employed pay 10.1% of annual earnings for outpatient treatment
Employers	Government-managed plans: 4.15% of standard monthly pay plus 0.5% of bonus; NHI: none	Part A: 1.45% of pay up to annual ceiling of $48,000; Part B: none	Medical care: employer and insured share 15% of cost; cash benefits: 5%, 7%, 9% or 10.45% of weekly pay up to ceiling	6.7% of pay on average	12.6% of pay	Hospitalization: none; outpatient: 10.1 percent of wages
State Subsidy	Government-managed plans: 16.4%; NHI: 50%	Part A: none in principle; Part B: 74% (1987)	Medical care: about 85%; cash benefits: none	None in principle	None in principle but applies part of auto insurance premiums and other user taxes	Hospitalization: all; outpatient: about 15%

*Not listed is the federal-state program for the poor, Medicaid. Costs are split about 57-43 between the federal government and each state. Eligibility varies from state to state but hinges on poverty-level status.

Source: Ministry of Health and Welfare

Table 2: U.S. Health Services and Supplies, Expenditures by Payer, 1985-89

(in billions of dollars)

	1985	1986	1987	1988	1989
Total	$404.7	$436.3	$475.2	$524.1	$583.5
Private	280.2	304.4	329.5	365.1	405.1
Businesses	117.1	128.0	137.8	154.4	173.4
Employer Share of Private Health Insurance Premiums	87.5	93.0	99.7	113.2	128.6
Employer Input for Medicare Hospital Insurance Trust Fund	20.3	23.3	24.7	26.4	28.5
Other Employer Expenses*	9.2	11.7	13.3	14.8	16.2
Households	151.2	164.0	178.3	196.1	215.6
Employee Share of Private Health Insurance Premiums Plus Individual Policy Premiums	30.3	33.7	37.9	40.6	45.6
Employee and Self-Employed** Payments Plus Voluntary Premiums Paid to Medicare Hospital Insurance Fund	24.0	27.6	29.5	31.4	33.9
Premiums Paid to Medicare Supplementary Medical Insurance Fund	5.2	5.2	6.1	8.7	11.3
Out-of-Pocket Health Spending	91.7	97.4	104.7	115.5	124.8
Nonpatient Revenues	11.9	12.4	13.5	14.6	16.1
Public	124.5	131.9	145.7	159.0	178.4
Federal Government	69.0	70.0	76.7	84.2	95.5
As Employer, Contributions to Private Health Insurance	4.3	4.0	4.8	6.4	8.0
Adjusted Medicare Outlays	20.3	18.0	19.5	20.8	24.8
Medicare	72.1	76.9	82.9	90.5	102.1
Less Premiums and Contributions Paid as Employer to Medicare	51.8	58.9	63.4	69.8	77.3
Other Health Program Outlays***	44.4	48.1	52.4	57.0	62.7
State and Local Governments	55.5	61.9	69.0	74.9	82.9
As Employer, Contributions to Private Health Insurance	11.9	12.8	13.9	15.8	17.4
Employer Contributions to Medicare Hospital Insurance Fund	2.2	2.7	3.1	3.3	3.6
Medicaid	18.6	19.8	22.9	23.9	26.9
Hospital Subsidies	7.8	10.0	11.2	12.4	13.9
Other****	15.0	16.6	18.0	19.5	21.1

Addendum: Percentage Breakdown of Total Expenditures

	1985	1986	1987	1988	1989
Businesses	28.9%	29.3%	29.0%	29.5%	29.7%
Households	37.4	37.6	37.5	37.4	36.9
(Out-of-Pocket)	(22.7)	(22.3)	(22.0)	(22.0)	(21.4)
Nonpatient Revenues	2.9	2.8	2.8	2.8	2.8
Federal Government	17.0	16.0	16.1	16.1	16.4
State and Local Governments	13.7	14.2	14.5	14.3	14.2

*Includes worker compensation, temporary disability insurance and in-plant health services.
**Includes one-half of self-employment contribution to Medicare Hospital Insurance Trust Fund.
***Includes Medicaid, health programs through the Departments of Defense and Veterans Affairs, Indian Health Service, Maternal and Child Health funding plus other public health, medical and general hospital programs.
****Includes other public and general assistance, including Maternal and Child Health.

Source: Health Care Financing Review, XII, No. 2 (Winter 1990), p. 130.

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